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UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

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an individual, JOHN KADES, an individual, ED WINTER, an individual, and DOES 1-10.

Defendants.

DEMAND FOR JURY TRIAL

INTRODUCTION

1. For the past nineteen months, the Los Angeles County Coroner's Office ("Coroner's Office") has been pursuing what can only be described as a vendetta against Valley Surgical Center, LLC ("Valley"), arising out of its investigation into the death of Paula Rojeski after weight loss surgery at Valley. The Coroner's Office has systematically engaged in conduct violating Valley's constitutional rights. The Coroner's Office and its representatives have falsified the available and known evidence regarding the Rojeski surgical procedure and misrepresented the cause of death by contending that this fabricated evidence demonstrates that the surgical procedure caused the death. The Coroner's Office has forwarded the same fabricated evidence to the LAPD Robbery-Homicide Division and to the next of kin of Paula Rojeski. In violation of the Coroner's Office own Security Hold, the Coroner's Office has leaked aspects of the as yet unreleased autopsy report and investigation to the media. A Coroner's Office representative, at a public forum, referred to the supposed facts she found and presented false facts that were readily identifiable as a reference to the Rojeski death at Valley.

2. Far from being an impartial investigative body seeking the truth, the Coroner has demonstrated a clear bias against Valley, which disqualifies it from continuing to investigate the Rojeski death. This bias has been manifested by,

COMPLAINT FOR DAMAGES AND INJUNCTIVE RELIEF

1 *inter alia*, (1) using a principal investigator who is a strident advocate of banning
2 ambulatory surgery centers from performing weight loss surgery and who was the
3 person whose initial report fabricated and falsified the surgical evidence on which
4 the Coroner has systematically relied; (2) placing a supposed “security hold” (the
5 legal basis of which has never explained) on its investigation to justify not
6 communicating its report to Valley while simultaneously communicating it to
7 others, including the Rojeski family; (3) threatening to release the autopsy report –
8 the investigation of which has to date taken 19 months – if Valley or anyone else
9 were to publicly disclose or complain of the wrongful actions of the Coroner’s
10 Office; (4) relying on the unverified allegations of an anonymous source; and (5)
11 obtaining access to Valley’s surgical offices by presenting a subpoena demanding
12 access for which it did not have the legal authority represented in the subpoena.

13 3. The Coroner’s actions (not all of which are recounted above) have
14 resulted in numerous violations of Valley’s constitutional rights and state laws and
15 the liberty and property interests protected by these state laws, including violations
16 of due process based on the deliberate falsification of evidence in the autopsy and
17 use of that report to trigger a criminal investigation, recommending disciplinary
18 proceedings, and jeopardizing Valley’s accreditation. In addition, the Coroner’s
19 Office has intimidated and chilled Valley’s exercise of its rights to free speech, to
20 petition the government, and to access the courts, violated its right to be free from
21 unreasonable search and seizure, deprived it of procedural and substantive due
22 process of law, and deprived it of equal protection of the law. Defendants have
23 engaged in a systematic campaign lasting over a year resulting in the deprivation
24 of Valley’s constitutional rights and threatened its very existence in doing so.

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Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 4. It is the Coroner's repeated threats to release the extant autopsy report
2 that brings Valley to seek *ex parte* relief, i.e., for a Temporary Restraining Order
3 to restrain the Coroner from taking further action, including release of the extant
4 autopsy report or any modified report pending a hearing on Valley's motion for
5 preliminary injunction, at which Valley will request that the Coroner be
6 preliminarily (and ultimately permanently) enjoined from further participation and
7 investigation into the death of Paula Rojeski or forwarding or divulging its current
8 report or any variant thereof. (This would not preclude Los Angeles County from
9 requesting that a coroner from another county or other independent body be
10 appointed to complete the investigation and issue a report not based on fabricated
11 evidence).

12 5. There is a grave likelihood that Valley's very existence will be fatally
13 destroyed if this Court does not act. Valley has already been severely damaged by
14 the conduct at issue in this case – its business has dramatically declined due to the
15 cloud over its head because of the implication that Ms. Rojeski died due to
16 Valley's actions, and it has spent large sums of money (including attorneys and
17 expert consultants) defending itself against the fabricated evidence and other
18 conduct of the Coroner's Office. If this false report is allowed to issue, Valley will
19 likely have its accreditation and certification withdrawn by The Joint Commission,
20 which accredits health care facilities in California. Without that accreditation,
21 Valley will be forced to close its doors.

PARTIES

23 6. Plaintiff Valley Surgical Center, LLC, is a California limited liability
24 company with a principal place of business in the County of Los Angeles.

27 Case No.

**COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF**

1 7. Defendant County of Los Angeles is a government entity operating
2 under the laws of the State of California. Defendant County of Los Angeles
3 oversees the Department of the Coroner (hereinafter collectively referred to as the
4 "Coroner's Office"). The Coroner's Office is a governmental entity operating
5 under the laws of the State of California and also operating under the regulations
6 of the County of Los Angeles.

7 8. Defendant Lakshmanan Sathyavagiswaran, M.D. is an individual
8 employed by the County of Los Angeles and is officially listed as the Interim Head
9 of the Los Angeles County's Department of the Coroner ("Sathyavagiswaran"). He
10 is being sued in his individual and official capacities.

11 9. Defendant Adrian Marinovich, M.D. is an individual who was
12 employed by the County of Los Angeles ("Marinovich"). He is being sued in his
13 individual capacity.

14 10. Defendant Raffi Djabourian, M.D. is an individual employed by the
15 County of Los Angeles as Senior Deputy Medical Examiner ("Djabourian"). He is
16 being sued in his individual capacity.

17 11. Plaintiff is informed, believes, and thereon alleges that Defendant
18 Denis C. Astarita, M.D. is an individual retained by the Coroner's Office as an
19 outside consultant with the title of Deputy Medical Examiner ("Astarita"). He is
20 being sued in his individual capacity.

21 12. Plaintiff is informed, believes, and thereon alleges that Defendant
22 Selma Calmes, M.D. is an individual retained by the Coroner's Office as an
23 outside consultant with the title of Deputy Medical Examiner ("Calmes"). She is
24 being sued in her individual capacity.

25
26
27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 13. Plaintiff is informed and believes and thereon alleges that Defendant
2 John Kades, is an individual employed by the County of Los Angeles as a Deputy
3 Coroner, with the rank of Captain within the Investigations Division of the
4 Department of the Coroner ("Kades"). He is being sued in his individual capacity.

5 14. Plaintiff is informed and believes and thereon alleges that Defendant
6 Ed Winter, is an individual employed by the County of Los Angeles as the
7 Assistant Chief Investigator, Operations Bureau, of the Department of the Coroner
8 ("Winter"). He is being sued in his individual capacity.

9 15. Plaintiff is uncertain as to the identity or capacity of the other
10 Defendants included herein as DOES 1 through 10, inclusive, and therefore sues
11 these Defendants by fictitious names. Plaintiff is informed and believes and
12 thereon alleges that said Defendants, DOES 1 through 10, inclusive, and each of
13 these, are liable to Plaintiff on the facts herein alleged and will seek leave of this
14 Court to amend this Complaint when true names are ascertained.

15 16. Plaintiff is informed and believes and thereon alleges that, at all times
16 herein mentioned, each of these Defendants was an agent, or employee of each of
17 the other co-Defendants and, in doing the things herein alleged, was acting in the
18 scope of his or her authority as such agent with the permission and consent of each
19 of the other co-Defendants.

20 17. Plaintiff is informed and believes, and thereon alleges, that, at all
21 times herein mentioned, each of the Defendants was the agent and/or employee
22 and/or co-conspirator of each of the remaining Defendants, and in doing the things
23 hereinafter alleged, was acting within the scope of such agency, employment
24 and/or conspiracy, and with the permission and consent of other co-Defendants.

25
26
27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 All acts alleged herein are alleged as part of a conspiracy to violate Plaintiff's
2 rights.

3 **JURISDICTION, VENUE AND DIVISION ASSIGNMENT**

4 18. The jurisdiction of this court over the subject matter of this action is
5 predicated upon *28 U.S.C. §§ 1331 and 1343*.

6 19. Venue is proper under *28 U.S.C. §1391(b)(2)*, and assignment to the
7 Western Division of this Court is proper, because a substantial part of the events
8 or omissions giving rise to the claims herein occurred in Los Angeles County,
9 California.

10 20. Plaintiff's federal claims arise under the United States Constitution,
11 in particular the First, Fourth, Fifth, and the Fourteenth Amendments. In addition,
12 Plaintiff's federal claims arise under federal law including, but not limited to, the
13 federal Civil Rights Act, *Title 42, United States Code §§ 1983*. The acts and
14 omissions of Defendants and others, as alleged herein, were committed by
15 Defendants and others, and each of them, under color and pretense of the
16 Constitution, statutes, ordinances, rules, regulations, practices, customs, patterns,
17 and usages of the State of California and/or of the counties referenced herein.
18 Supplemental jurisdiction for the state claims is appropriate pursuant to *28 U.S.C.*
19 *§ 1337(b)*.

20 **OVERVIEW OF RELIEF SOUGHT**

21 21. Valley Surgical Center, LLC ("Valley") seeks injunctive relief and
22 damages against the Coroner's Office, its agents and employees and outside
23 retained consultants, including but not limited to Dr. Lakshmanan
24 Sathyavagiswaran, Dr. Adrian Marinovich, Dr. Raffi Djabourian, Dr. Denis C.
25 Astarita, Dr. Selma Calmes, and Ed Winter restraining them from having further

27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 participation in the death investigation of Paula Rojeski. In this 19 month
2 investigation, the Coroner's Office and its agents have engaged in reckless and
3 illegal conduct by drafting and disseminating a false autopsy report concerning the
4 death of Paula Rojeski.

5 22. The Defendants' conduct violated Plaintiff's rights under the First,
6 Fourth, Fifth and Fourteenth Amendments (and their California analogues) –
7 including depriving them of the following statutes:

- 8 a. Violate its due process right to a governmental investigation not
9 based on false and/or fabricated evidence;
- 10 b. Violate its due process right to an unbiased governmental
11 investigation not based on false and/or fabricated evidence;
- 12 c. Violate its due process right not to have exculpatory evidence
13 destroyed in bad faith;
- 14 d. Violate its First Amendment and due process rights to petition the
15 government and to have access to the courts;
- 16 e. Violate its First Amendment rights to engage in lawful speech
17 without being retaliated against for doing so;
- 18 f. Violate its First Amendment rights to engage in lawful speech
19 without having its right to do so infringed upon and chilled by the
20 actions of governmental agents or employees;
- 21 g. Violate its due process rights to petition the government and to
22 have access to the courts;
- 23 h. Violate its Fourth Amendment right not to be subjected to an
24 unlawful search and seizure;
- 25 i. Violate its equal protection and/or due process right not to be
26 singled out for irrational and/or arbitrary discriminatory treatment.

27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 23. Defendants' conduct also violated, *inter alia*, (1) Cal. Gov't Code §
 2 27491.4 (coroner must act in accordance with medico-legal practice); (2) Cal.
 3 Gov't Code § 27491.5 (coroner's report must be in accordance with facts
 4 ascertained from inquiry, autopsy and other scientific findings); (3) Cal. Gov't
 5 Code § 27491.45 and Cal. Health & Safety Code § 7151.2 (regarding appropriate
 6 organ harvesting); (4) Civil Code § 815.6 (violation of mandatory duty), and (5)
 7 Cal. Civil Code § 52.1 (use of threats, intimidation or coercion to interfere and
 8 attempt to interfere with exercise of rights secured by Federal or State Constitution
 9 or law.

10 **The Bariatric Surgery and the Failure by the Coroner to Preserve**
 11 **Evidence**

12 24. On September 8, 2011, Paula Rojeski, a 55 year old female,
 13 underwent laparoscopic surgery at Valley Surgical Center for placement of an
 14 adjustable gastric band to treat her longstanding obesity. As demonstrated by the
 15 Anesthesia Record from the Rojeski surgery contained in the Figures below, the
 16 surgery lasted for 30 minutes, with a start time of 9:15 a.m. and a finish time of
 17 9:45 a.m. When the attending surgeon closed the patient, there were no
 18 indications of bleeding or complications.

Procedure		Anesthesia Record		
Leap Band		Date	9/8/11	Allergies
OR TIMES		D-Patient Identified		
START	FINISH	D-Chart Reviewed		
8:55	11:15	D-Consent signed		
OP 9:15		D-ANPO Since 0855 AM/PM		
OP 9:45		D-Time Out Conducted		
		D-Pneumatic Comp to LE		
TYPE OF ANESTHESIA:				
GENERAL: D-IV Dose				
MAC: D-Nasal O2				
REGIONAL: D-Spinal				
D-Inhalation				
D-Mask O2				
D-Epidural				
D-Oral/Nasal Airway				
D-Auxiliary				
D-Block				
PRERANESTHETIC VITAL SIGNS:				
BP: 141/90 P 84 R 16 Temp 98.2 O2 SAT 100%				

OPERATING ROOM RECORD				
Age: 55	Sex: F	Allergies: MPA		
Type of Anesthesia: <input checked="" type="checkbox"/> General <input type="checkbox"/> MAC <input type="checkbox"/> Local <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Block				
Patient in Room	Anesthesia Start	Anesthesia End	Surgery Start	Surgery End
0855	0855	11:15	0915	0945
Surgeon: GEE		Assistant: CHINN		
Anesthesia Provider: <i>Surgeon</i>		AND INJUNCTIVE RELIEF		

1 25. From 9:45 a.m. until approximately 10:55 a.m., the patient recovered
2 from the anesthesia.¹ The anesthesiologist was available and continued to monitor
3 the patient after the surgery ended. (The anesthesiologist remained by the patient's
4 side and continued to observe the patient until 11:15 a.m. which is the reason that
5 the Operating Room Record reflects that the anesthesiologist ended his monitoring
6 at 11:15 and the patient was turned over to LA City Firemen for transport to the
7 hospital). At 10:55 a.m., the patient suffered PEA (pulseless electrical activity)
8 and cardiac arrest. The surgeon at Valley Surgical Center initiated CPR and
9 promptly called 911.

10 26. LA City Firemen responded and initiated their own vigorous CPR on
11 the deceased. The significant resuscitative trauma and injuries included
12 anterolateral fractures of the left rib 3, and right ribs 2, 3, 4, 5, 6, and 7. There
13 were also resuscitative injuries resulting in abrasions of the midline anterior chest.

14 27. Prior to the initiation of resuscitation, there was no blood coming
15 from the laparoscopic incisions. However, following the resuscitation efforts from
16 LA City Firemen, which broke her ribs, damaged her lungs, and caused
17 hemorrhage into the mediastinum, the LA City Firemen also observed blood
18 coming from the laparoscopic incisions. The firemen then transported the patient
19 to West Hills Medical Center at 11:15 a.m., where the patient was pronounced
dead at 11:41 a.m.

20 28. The Coroner's Office was informed of the death at 12:17 p.m. on
21 September 8, 2011, and the case was accepted by Coroner's Representative Hiath
22 with the Coroner's Reference No. 2011 1-05916.

23
24

¹ The anesthesiologist stayed with the patient, which is why the records show 11:15 a.m.
25 for the "Anesthesia End" time. However, the administration of anesthesia ceased at 9:45
26 a.m. the same time as the conclusion of the surgery.

27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 29. Following the patient's death, there was extensive post-mortem tissue
2 and bone procurement by OneLegacy, Inc. ("OneLegacy"), a tissue procurement
3 company. The deceased's sister, Michele Pelter, gave authorization over the phone
4 to OneLegacy, Inc. to harvest the heart, skin, and bones from the deceased. The
5 authorization was given at 7:55 a.m. on September 9, 2011, the day following the
6 surgery, but prior to the autopsy. Unfortunately, the Coroner did nothing to
7 prevent the deceased's organs from being harvested, which interfered with the
8 death investigation by failing to preserve exculpatory evidence, the value of which
9 was known at the time. The Coroner did not even observe the harvesting.

10 30. On September 12, 2011, the Los Angeles County Coroner's Office
11 conducted an autopsy of Ms. Rojeski's body. The Coroner's Report states that
12 "skin and bones, legs, arms, and back" were harvested from the patient's body
13 before the autopsy. The organ procurement was so extensive that the pathologist
14 wrote in the Coroner's Report, "Rigor mortis cannot be assessed due to prior organ
15 procurement." *See* Coroner's Rojeski Final Report, attached hereto as Exhibit
16 "6."

17 31. The Coroner's Office knew that the deceased had suffered from PEA
18 (pulseless electrical activity) which is frequently caused from a pulmonary
19 embolism resulting from dislodging of blood clots from the lower extremities.
20 When the paramedics arrived to transport Ms. Rojeski to the hospital, they knew
21 about her PEA condition and her medical records accompanied her to the hospital.
22 Indeed, the Hospital Emergency Room report and the report from the harvesting
23 company all confirm Ms. Rojeski's PEA condition.

24 32. Despite this knowledge, the Coroner's Office allowed OneLegacy
25 organ procurement, without supervision, to extensively harvest bones from the
26 lower extremities prior to autopsy destroying any opportunity of discovering

27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 possible blood clots in the lower extremities which may have led to a pulmonary
2 embolism. Such exculpatory evidence, was consciously and recklessly
3 disregarded by the Coroner's Office by its allowing OneLegacy to harvest
4 Rojeski's body for organs and tissue without significant limitations. Such
5 evidence, which is now destroyed, cannot be obtained by other means. Therefore
6 the Coroner should have denied harvesting of tissue from the lower extremities.
7 Further, the Coroner should have also denied harvesting of the heart and lungs as
8 well, but did not.

9 33. Instead, the Coroner's Office did not observe the harvesting of the
10 tissues and bones or substantially or significantly limit in any way the harvesting
11 procedure. Nor did the Coroner's Office limit in any way the alteration and
12 disruption of the deceased's body, which interfered with the investigation, from
13 the skin and bones from the harvesting, as mandated by *California Health &*
14 *Safety Code* § 7151.2 and *Cal. Gov't Code* §27491.45. The Coroner's Office
15 merely requested that OneLegacy's "recovery avoids operations site."

16 34. Following the completion of the autopsy, the Coroner's office also
17 failed to embalm the body of the deceased, despite having the statutory authority
18 to do so under *Cal. Gov't. §27471*. Thus, the Coroner's Office allowed
19 destruction of the heart valves which it incorrectly interpreted as normal at
20 autopsy. As ample evidence shows, Ms. Rojeski had calcification of the heart
21 valves and moderate aortic regurgitation as evidenced by radiographic imaging.
22 Again the value of this exculpatory evidence was known at the time of destruction
23 of evidence. Rather than embalm the body and protect evidence which could not
24 be recovered by other means in this case where the cause of death was unknown,
25 the Coroner's Office instead chose to do a shoddy autopsy which missed the
26
27

Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 significant fact that the heart valves were damaged and allowed burial with
2 decomposition of the body.

3 35. Any attempt to exhume Mrs. Rojeski's body for a re-examination
4 would be utterly useless, thereby permanently depriving Valley of this evidence.
5 Such spoliation of evidence, owing to the unsupervised tissue harvesting, and
6 failure to embalm the body, constitutes multiple violations of law enforcement's
7 duty to preserve evidence that might be expected to be exculpatory, as well as play
8 a significant role in any investigation.

9 36. The value of this evidence was known at the time of its destruction as
10 being essential to Valley and its medical staff regarding any cause of death or
11 criminal investigation. The failure to collect and preserve such evidence
12 materially affects the possibility of homicide charging recommendations and/or
13 decisions. The failure to collect and preserve evidence substantially affects the
14 Coroner's recommendations for further disciplinary action by the California
15 Medical Board against Valley and its medical staff, and it significantly affected
16 the outcome of the Rojeski Final Report, which the Coroner seeks to release.

17 37. Prejudice to Plaintiff has accrued from the foregoing failure to
18 preserve evidence as that evidence would have further confirmed that Plaintiff's
19 explanation of the circumstances of death are correct and would have further
20 undermined any suggestion that the death qualifies as a homicide or was the result
21 of gross negligence by Valley. It is especially prejudicial to Valley because the
22 Coroner's Office refuses to rule out homicide as the cause of death, and also
23 recommends that Valley and two members of its medical staff be referred to the
24 California Medical Board for disciplinary proceedings.

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Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 **The Anonymous Letter and Illegal Search of Valley Surgical Center**

2 38. On October 17, 2011, the Coroner's Office received an "anonymous
 3 letter" from an individual claiming that during the September 8, 2011 surgery: (1)
 4 oxygen tanks were empty, (2) fluids leaked on the floor, (3) the anesthesiologist
 5 recorded false information, (4) the monitoring equipment was broken, and (5) the
 6 times of the cardiac arrest were falsified² (the "Anonymous Letter").

7 39. In late November, the Coroner's Office announced that it wanted to
 8 inspect the premises of Valley and in particular inspect Valley's anesthesia
 9 equipment and other medical equipment. Valley then learned that the Coroner's
 10 Office had retained Selma Calmes, M.D., as its Anesthesia Consultant for the
 11 Rojeski case and that she would be accompanying the Coroner's team to the
 12 inspection of Valley's facilities.

13 40. On or about December 1, 2011, prior to the Coroner's site inspection,
 14 Valley's counsel, Robert Silverman, sent a letter to the Coroner's Office protesting
 15 Dr. Calmes as the Consulting Anesthesiologist for the Rojeski investigation. *See*
 16 *December 1, 2011 letter from Robert Silverman to Coroner's Office, attached*
 17 *hereto as Exhibit "I."* The letter noted that Dr. Calmes had a publicly
 18 documented professional bias against ambulatory surgery centers. *See Id.* Dr.
 19 Calmes publicly stated in a previous autopsy report issued by the Coroner's Office
 20 in January 2011 that she considered any ambulatory outpatient facility to be an
 21 inappropriate platform for gastric banding procedures for patients with sleep

22
 23 ² Nevertheless, nowhere in the Rojeski Final Report was there any verification of any of
 24 these allegations. In fact, Valley refuted all of the allegations in the Anonymous Letter as
 25 Valley provided full and complete surgical logs, medical records, and equipment
 26 maintenance logs to the Coroner's Office which disproved most, if not all, of the
 27 allegations in the Anonymous Letter.

Case No. _____

COMPLAINT FOR DAMAGES
 AND INJUNCTIVE RELIEF

1 apnea. *See Exhibit "1" attached hereto and incorporated herein.*³ Despite her
 2 obvious bias, the Coroner's Office refused to utilize a different anesthesiology
 3 consultant and insisted that the inspection would go forward with Dr. Calmes in
 4 attendance. *See December 2, 2011 letter from County Counsel to Robert*
 5 *Silverman attached hereto and incorporated herein as Exhibit "2."*

6 41. Notwithstanding the foregoing, the Coroner's Office issued an illegal
 7 Administrative Subpoena on December 5, 2011 signed by John Kades, Deputy
 8 Coroner, which improperly demanded that Valley consent to a search of its
 9 premises and equipment. *See Exhibit "3".* The Administrative Subpoena was
 10 issued without any judicial adjudication or judicial review and thus was illegal on
 11 its face in terms of compelling a search of Valley's premises by Dr. Calmes,

12 42. The Coroner's Office appeared on December 5, 2011 at Valley's
 13 facilities with this unauthorized and unlawful subpoena compelling Valley to
 14 allow the Coroner's Office and "its duly appointed deputies" to access the
 15 anesthesia equipment used on Ms. Rojeski.

16 43. The Coroner's Office admitted at the time of the inspection that they
 17 issued the subpoena solely to compel Valley to allow Dr. Calmes onto the
 18 premises.⁴ *See Exhibit "3" attached hereto and incorporated herein.*

19
 20 ³ In that January 2011 autopsy report, Dr. Calmes cites to outdated guidelines issued by
 21 the American Society of Anesthesiologists in 2006. The overwhelming majority of
 22 scientific literature published since 2006 on this topic approves and endorses gastric
 23 banding procedures in an outpatient setting. Thus, Dr. Calmes not only had a publicly
 24 documented bias against Valley, but had relied on outdated scientific data to support her
 25 biased position. *See Exhibit "2" attached hereto and incorporated herein.* This fact was
 26 called to the Coroner's attention in a March 2011 letter from Valley's attorney, Robert
 27 Silverman, to the Coroner in March 2011.

⁴ The issuance of an administrative subpoena to compel a "search" is illegal.

1 44. Because of the close nexus in time between Valley protesting Dr.
2 Calmes appointment to the Rojeski investigation on December 1, 2011, and the
3 issuance of the illegal Administrative Subpoena on December 5, 2011 compelling
4 Valley, under threat of criminal contempt prosecution, to allow Dr. Calmes onto
5 its premises, Plaintiff alleges, on information and belief, that this action was in
6 retaliation for Valley's lawful exercise of its First Amendment right to petition the
7 government and object to Dr. Calmes' participation, and that Valley's prior
8 complaint regarding Dr. Calmes was a motivating factor in unlawfully presenting
9 the administrative subpoena to search Valley's premises.

10 45. At the inspection, Valley Surgical showed the Coroner's
11 representatives its records demonstrating the Anonymous Letter was false:

- 12 a. there had been no defect in the equipment;
- 13 b. the oxygen system functioned correctly at the time of surgery;
- 14 c. the equipment had been serviced only 10 days earlier without
15 incident, and;
- 16 d. two surgeries took place at the facility in the same operating room
17 only 45 minutes after the Rojeski surgery without incident,
18 utilizing the same equipment and oxygen system.

19 **The Coroner's Office Breached its Own Security Hold on the**
Investigation

20 46. For the next four months, Valley heard nothing from the Coroner's
21 Office. Whenever Valley asked about the status of the investigation, the Coroner's
22 Office replied that there was a "Security Hold" on the investigation, and nothing
23 could be released or discussed until the investigation was completed.

24 47. During the same four months, Valley discovered that an ex-employee
25 had filed a "whistleblower" lawsuit against Valley, in which the whistleblower

27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 admitted to having made a written complaint to the Coroner's Office regarding the
2 circumstances of Rojeski's death. Valley responded not only to the complaint, but
3 also provided the Coroner's Office with information that refuted and disproved the
4 allegations in the Whistleblower complaint and the Whistleblower's subsequent
5 amended complaint. In the amended complaint, the plaintiff/Whistleblower
6 significantly and substantially changed and revised the allegations concerning
7 Rojeski's death. Valley requested the opportunity to discuss the alleged
8 complaints with the Coroner's Office. However, the Coroner's Office, again,
9 declined to meet with Valley's representatives replying that there was a "Security
10 Hold" on the investigation, and nothing could be discussed until the investigation
11 was completed.

12 48. Then on or about April 6, 2012, several major news outlets, including
13 the Los Angeles Times and the Orange County Register published a story that the
14 Coroner's Office had referred the Rojeski investigation to the Los Angeles Police
15 Department Robbery-Homicide Division. Thus, despite the Coroner's "Security
16 Hold" on the investigation, the Coroner leaked its LAPD investigative referral to
17 the news media. Valley's counsel spoke with Detective Dan Myers of the LAPD
18 Robbery-Homicide division, who confirmed the Coroner's Office referral and that
19 the Coroner's Office had not forwarded to the LAPD Valley's two letters which
20 showed that the allegations regarding the death of Rojeski in both versions of the
21 Whistleblower complaint were false. This was in violation of the Coroner's legal
22 directive in Government Code § 27491.1, which states that the Coroner's report to
23 law enforcement must include "information received by the Coroner relating to the
24 death."

25 49. Despite an active investigation and a Security Hold on the
26 investigation, Plaintiff Valley is informed and believes and thereon alleges that

27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 Defendant Calmes breached the Security Hold during an active investigation when
 2 she gave a presentation on September 21, 2012 titled "Ambulatory Surgery
 3 Disasters" at Hotel Nikko in San Francisco. Calmes, appearing under the title of
 4 "Los Angeles County Coroner/Medical Examiner," violated the Coroner's
 5 Security Hold by discussing two Lap Band deaths where she was the appointed
 6 Anesthesia Consultant to the Coroner's Office.

7 50. Her charts and slides intentionally and openly criticized surgery
 8 centers working with 1 800 GET THIN, which include Plaintiff Valley. She
 9 violated the Coroner's Security Hold on the Rojeski investigation by intentionally
 10 disclosing unconfirmed information regarding the Rojeski death and repeating her
 11 discredited professional opinions regarding bariatric surgeries in ambulatory
 12 surgery centers. In fact, she even put up a billboard of 1 800 GET THIN's
 13 advertising in her speech and related that there were two related Lap Band deaths.
 14 Obviously, one of those two deaths was the death of Paula Rojeski, and as of
 15 September 2012, this matter was still under investigation and the Coroner's
 16 Security Hold. *See Exhibit "5."*

17 51. Approximately two weeks before that speech, Valley submitted a
 18 written letter with medical records to the Coroner's Office demonstrating how
 19 Paula Rojeski had a prior, undisclosed history of prescription weight loss
 20 medication use, including Fen-Phen and that she had admitted in court documents
 21 to having suffered significant cardiac damage. *See Exhibit "4" attached hereto.*
 22 Valley's presentation of this evidence to the Coroner's Office called into the
 23 question the entire methodology of the Rojeski investigation in general with lack
 24 of any investigation into her past medical history. The close nexus in time between
 25 Valley's September 8th letter to the Coroner's Office and Defendant Calmes
 26 speech, in her official capacity as Deputy Medical Examiner for the Coroner's

27 Case No. _____

COMPLAINT FOR DAMAGES
 AND INJUNCTIVE RELIEF

1 Office, suggests that the later action was partly in retaliation for Valley's exercise
 2 of its First Amendment rights, and Valley so alleges on information and belief.

3 **Plaintiff Valley Conducts Its Own Investigation into Paula Rojeski**

4 52. In September, 2012, Paula Rojeski's estate filed a wrongful death
 5 action against Valley and its medical staff. By this time, the Coroner's
 6 Investigation had been pending for 12 months without any report or indication
 7 when a report would be issued.

8 53. Valley uncovered a series of medical records which showed Ms.
 9 Rojeski had a severely compromised, but undisclosed heart condition from her use
 10 of Fen-Phen and other weight loss medications during the years 2001-2002, and
 11 again during 2009-2010. In addition, Valley uncovered documents showing that
 12 Ms. Rojeski was a lead plaintiff in a civil lawsuit against the makers of Fen-Phen
 13 where she admitted to having suffered severe cardiac damage from Fen-Phen
 14 usage. *See Exhibit "4" attached hereto and incorporated herein.*

15 54. Not less than ten times in statements to Valley Medical personnel, the
 16 deceased stated she had no prior heart damage when in fact she had filed a lawsuit
 17 in 2003 entitled *Paula Rojeski v. Wyeth, et. al.*, Orange County Superior court
 18 Case No. 03CC00687, claiming severe heart injury from her use of Fen Phen in
 19 2001 and 2002. Ms. Rojeski also concealed from Valley Medical personnel that
 20 she commenced taking the prescription weight loss medication, Phentermine, in
 21 2009. *See Exhibit "16" attached hereto and incorporated herein.* In fact, she
 22 obtained the Phentermine in 2009, from the same physician from whom she had
 23 obtained the Fen Phen in 2002. *Id.*

24 55. Ms. Rojeski also concealed that she had gone to the emergency room
 25 at Saddleback Medical Center in Lake Forest, California, on August 11, 2011,
 26 which was only 28 days prior to her September 8, 2011 surgery, with malignant

27 Case No. _____

COMPLAINT FOR DAMAGES
 AND INJUNCTIVE RELIEF

1 blood pressure of 205/150, radiating pain in her neck and shoulders, heart
 2 palpitations, and an abnormal EKG. *See Exhibit "15" attached hereto and*
 3 *incorporated herein.*

4 56. Valley provided these previously undisclosed and concealed records
 5 to the Coroner's Office in Fall 2012, several months before the Rojeski Final
 6 Report was completed.

7 57. With her weakened heart from the prior Fen-Phen usage, Ms. Rojeski
 8 was not a good candidate for laparoscopic surgery because she had a compromised
 9 heart, and could not sustain events during surgery which would not have affected a
 10 healthy patient. *See Declaration and expert report attached thereto of Dr. Terry*
 11 *Simpson, attached hereto as Exhibit "10".* Dr. Simpson's report states that Ms.
 12 Rojeski likely died after surgery because of her undisclosed injury.

13 58. All of this uncovered information, which had been concealed from
 14 Valley and its medical staff by Ms. Rojeski, was addressed and documented in a
 15 series of letters to the Coroner's Office. The letters were dated September 7, 2012,
 16 October 3, 2012, October 8, 2012, October 25, 2012, November 6, 2012,
 17 November 13, 2012, November 16, 2012, November 21, 2012, December 6, 2012,
 18 and December 10, 2012. The letters contained more than 1,000 pages of Paula
 19 Rojeski's medical records, and other relevant documents.

Valley Surgical's Review of the Coroner's Report.

20 59. While sending the various letters, Valley repeatedly asked to meet
 21 with the Coroner's Office to review the evidence that Valley had presented
 22 regarding Ms. Rojeski. The Coroner's Office, claiming that there was a Security
 23 Hold on the investigation, rebuffed Valley's requests.

24 60. In January 2013, Valley's Counsel, Centurion, heard through legal
 25 representatives of Ms. Rojeski's estate that the Coroner had shared the findings of
 26

27 Case No. _____

COMPLAINT FOR DAMAGES
 AND INJUNCTIVE RELIEF

1 its autopsy report concerning Ms. Rojeski's death (the "Rojeski Final Report")
 2 with representatives of Ms. Rojeski's estate. Valley then immediately renewed its
 3 demand for a meeting with the Coroner's Office.

4 61. On January 15, 2013, more than 16 months following the deceased's
 5 death, the Coroner's Office met with Valley's representatives. After admitting to
 6 having revealed the contents of the Rojeski Final Report to Rojeski's estate
 7 representative, the Coroner's Assistant Chief Investigator, Ed Winter, agreed to
 8 release a copy of the Rojeski Final Report to Valley's legal counsel who were in
 9 attendance. *See Exhibit "6," to be filed under seal separately from this*
 10 *Complaint.*

11 62. The Coroner's representatives stated that Valley had one week in
 12 which to review the Rojeski Final Report. However, Ed Winter emphasized that
 13 the Rojeski Final Report would not be modified or revised. He stated that, at best,
 14 the Coroner's Office might issue a supplemental report.

15 63. At the conclusion of the meeting, Investigator Winter stated that the
 16 Rojeski Final Report was being released to Valley's legal counsel under an
 17 understanding of confidentiality. Winter further elaborated by saying that, if
 18 anyone from Valley released or disclosed the Rojeski Final Report to any third
 19 party, that the Coroner's Office would then immediately release and distribute the
 20 Rojeski Final Report to the public. Defendant Winter additionally stated "I don't
 21 want to hear about this in any report from any source." Winter's statements were
 22 reasonably interpreted by Valley and its legal representatives as a threat and
 23 intimidation against Valley presenting any complaints about the Coroner's
 24 investigation or any complaints about the Rojeski Final Autopsy Report to any
 25 government agency or judicial forum outside of the Coroner's Office. As a result,
 26 Valley has felt constrained from filing complaints regarding the Coroner's

27 Case No. _____

COMPLAINT FOR DAMAGES
 AND INJUNCTIVE RELIEF

1 Office's violations of its rights, including filing administrative tort claims under
 2 Govt. Code § 910.⁵

3 64. The Rojeski Final Report stated the mode of death for the deceased
 4 was "undetermined." (*Exhibit "6," to be filed separately under seal*). More
 5 specifically:

- 6 a. the Coroner's Office could not rule out that the death was a homicide;
- 7 b. the Coroner's Office found the attending Anesthesiologist, Dr. Demming
 Chau, and the attending Surgeon, Dr. Julius Gee, were grossly negligent
 and that they both should be referred over for further disciplinary
 proceedings by the California Medical Board;
- 8 c. the Coroner's Office found (without any factual substantiation) that
 Valley did not comport itself within the bounds of the standards of due
 care.

9 65. The Rojeski Final Report contains a separate opinion by Dr. Selma
 10 Calmes, who was retained as a Consulting Anesthesiologist by the Coroner's
 11 Office. Her factual findings erroneously declare on page 2 starting at line 5:
 12 "The inhalation anesthetic isoflurane was stopped at 0945, and circuit gas flow
 13 was increased, to remove isoflurane from the system. **No further anesthetic**
 14 **drugs appear to have been given for the remaining 1 1/2 hrs of surgery**, on
 15 review of the anesthesia record." (Emphasis added).

16 21
 17 22 ⁵ Valley's legal representatives have only shown the report to the seven retained experts
 18 for purposes of refuting the conclusions contained in the Rojeski Final Report of gross
 19 negligence and sub-standard care. However, Valley's legal representatives have refrained
 20 from filing any public complaint regarding Valley's allegations of violations of its rights
 21 by the Coroner's Office as Valley has feared, and continues to fear, that the Coroner's
 22 Office would retaliate by officially releasing the Rojeski Final Report in its current form
 23 with all of its false findings and conclusions.

24 24 Case No. _____

25 25 COMPLAINT FOR DAMAGES
 26 26 AND INJUNCTIVE RELIEF

1 66. To the contrary, the medical and surgical records clearly state that the
 2 surgery ended at 9:45 a.m., the same time the anesthesia was stopped. There was
 3 no "remaining 1-1/2 hours of surgery" without anesthesia. Calmes thus
 4 erroneously claims that the patient was therefore awake during the last hour of her
 5 surgery, though paralyzed while bleeding to death with the surgeon standing there.
 6 This is erroneous because the patient was closed up at 9:45 a.m. and then placed in
 7 recovery and thus there was no need to be administering any more anesthesia. The
 8 surgeon had completed his task and closed up Ms. Rojeski approximately 75
 9 minutes before she went into cardiac arrest.

10 67. Dr. Calmes complained that she was unable to read the records and
 11 that "The hand-written anesthesia record is nearly unreadable, even using a
 12 magnifying glass." However, the records supplied to the LA Coroner's Office
 13 were in no manner illegible and are reproduced in sufficient clarity as shown
 14 below.

15 **FIGURE 1**

Procedure		Anesthesia Record	
Procedure		Date	9/8/11
Procedure		Allergies	MRSA
OR TIMES		TYPE OF ANESTHESIA:	
START	FINISH	D-Patient Identified	GENERAL: <input checked="" type="checkbox"/> Intravenous Inhalation
8:55	11:15	D-Chart Reviewed	MAC: <input type="checkbox"/> Nasal O2 <input checked="" type="checkbox"/> Mask O2
ANESTH	ANESTH	D-Consent signed	REGIONAL: <input type="checkbox"/> Spinal <input checked="" type="checkbox"/> Epidural <input checked="" type="checkbox"/> Oral/Nasal Airway
OP	OP	D-NPO Since AM	Auxiliary: <input type="checkbox"/> <input checked="" type="checkbox"/> Bladder Block
9:15	9:45	AM/PM	
Time Out Conducted		PRERESTHETIC VITAL SIGNS:	
D/Pneumatic Comp to LE		BP: 141/92	Temp: 97.6
Patient Safety: <input checked="" type="checkbox"/> Anesthesia Machine Checked <input checked="" type="checkbox"/> Safety Belt On		O ₂ SAT: 98%	
<input type="checkbox"/> Pressure Points Checked and Padded		ANESTHESIA PROVIDER:	
<input checked="" type="checkbox"/> Arms Tucked <input type="checkbox"/> Axillary Roll		Dorothy Chen, MD Signature: Chen, MD	
Eye Care: <input checked="" type="checkbox"/> Ointment <input type="checkbox"/> Saline <input type="checkbox"/> Taped <input type="checkbox"/> Goggles <input type="checkbox"/> Pads		SURGEON: Dr. G. Lee	
IVs: ER: <input type="checkbox"/> GUE: <input type="checkbox"/> GLE: <input type="checkbox"/> Other: _____		ASA PS: I IV: E	
Angio No: 320-G		PRERESTHETIC STATE: <input type="checkbox"/> Calm <input type="checkbox"/> Apprehensive	
pt is dry (dehydrated) pre-op before op. X		TIME: 10:00 AM	
TIME: 10:00 AM		AGENT3: <input checked="" type="checkbox"/>	

27 Case No. _____

COMPLAINT FOR DAMAGES
 AND INJUNCTIVE RELIEF

1 68. The records unquestionably indicate the times of the surgery and
 2 anesthesiologist's supervision which the Coroner's Consultant has ignored.
 3 Instead, the Consultant fabricated and falsified facts that were patently
 4 contradicted by the medical records. Moreover, if the records were so illegible,
 5 then Dr. Calmes and the rest of the authors of the Rojeski Final Report should
 6 never have been so adamant and confident in their findings and conclusions.

7 69. The Anesthesia Record unambiguously specifies the start time of the
 8 surgery as 9:15 a.m. and end time of the surgery as 9:45 a.m., and the writing is
 9 both clear and legible in direct contravention of the claim from the consultant.

10 70. The Operating Room Record completed by the nurse also clearly
 11 specifies the start and end time of surgery:

12 **FIGURE 2**

13

14 **OPERATING ROOM RECORD**

15 Age: 55 Sex: F Allergies: MPA

16 Type of Anesthesia: General MAC Local Spinal Epidural Block

Patient in Room	Anesthesia Start	Anesthesia End	Surgery Start	Surgery End
0855	0855	115	0915	0945

17 Surgeon: GEE 10/24/13 Assistant: CINN

18 Anesthesia Provider: Planned Anesthesia

19 Given the unambiguous medical records, the factual findings from the Anesthesia
 20 Consult cannot be supported.

21 71. Dr. Calmes states in her portion of the Rojeski Final Report:

22 “If there was cerebral perfusion during this time (we can anticipate
 23 that cerebral flow was present for at least some part of the next 1 1/2 hrs
 24 even though she was in a steep head-up position, which works against
 25 adequate cerebral blood flow when BP is low), **she had to be feeling pain**
 26 **and was conscious but paralyzed as she probably bled to death.**

27 Case No. _____

COMPLAINT FOR DAMAGES
 AND INJUNCTIVE RELIEF

1 72. Dr. Calmes, without any justification or confirmation whatsoever,
 2 and, with complete disregard for the medical records and surgical logs, goes on to
 3 say:

4 “Strangely the anesthesiologist realized the patient could not tolerate the
 5 anesthetic agent (it was turned off at 0945) but told the surgeon all was well.
 6 This patient was probably awake and feeling pain as she proceeded along
 7 the path to her death over the next 1 ½ hours.” (Emphasis added).

8 73. However, the undisputed medical records, as shown from the
 9 excerpts above in Figures 1 and 2 clearly demonstrate (1) anesthesia was initiated
 10 at 8:55 a.m. (2) surgery commenced at 9:15 a.m. and (3) surgery ended at 9:45
 11 a.m. The patient was not awake and paralyzed for 1 ½ hours of surgery, feeling
 12 pain and bleeding to death as Calmes falsely and outrageously proclaims. There is
 13 no evidentiary basis for these false statements in the Final Autopsy Report. This
 14 reckless conduct was done as part of Coroner’s Office’s concerted effort to harm
 15 Valley by instilling terror and outrage in anyone reading the report.

16 **Other Medical Examiners Blindly Adopt Dr. Calmes’ Erroneous**
Findings

17 74. The Coroner’s pathologists performing the autopsy, Dr. Adrian
 18 Marinovich and Dr. Raffi Djabourian, state at page 12-13 of their Report:

19 “The anesthesiology consultant report indicates that there was gross
 20 negligence on the part of the anesthesiologist, in that he failed to meet basic
 21 standards of anesthesia care, in particular: failure to adequately assess the
 22 patient’s condition during surgery, to communicate the patient’s
 23 deteriorating condition to the surgeon, **and to provide pain relief and**
 24 **amnesia while the patient was paralyzed during surgery.”** (Emphasis
 25 added).

26
 27 Case No. _____

COMPLAINT FOR DAMAGES
 AND INJUNCTIVE RELIEF

1 75. Thus, the pathologists assigned to the Rojeski investigation decided
2 to blindly rely upon and entirely premise their own allegedly independent findings
3 and conclusions on Dr. Calmes' false factual statements and inaccurate
4 conclusions.

5 76. The repeating of the erroneous findings and conclusions by Dr.
6 Calmes was continued by others within the Coroner's Office who were assigned to
7 investigate the Rojeski matter. The portion of the Rojeski Final Report authored
8 by Drs. Marinovich and Djabourian states:

9 “Certifying the manner of death as homicide vs. accident would require
10 knowledge of whether or not this death resulted from a conscious disregard
11 for the patient's safety. The currently available information does not allow
12 for a conclusion that the surgeon or anesthesiologist intentionally
13 disregarded the patient's safety. The manner of death thus could not be
14 determined.”

15 77. The statement is internally inconsistent and illogical. Since there is
16 no evidence of intentional disregard of the patient's safety or any “knowledge”
17 that would indicate a homicide, the only possible explanation for the patient's
18 death is that it was an accident.

19 78. The Surgical Consultant retained by the Coroner's Office for the
20 Rojeski Final Report, Dr. Denis Astarita, states “the likely manner of Death will be
21 Accident.” To ignore this obvious fact and classify this death as “undetermined”
22 ignores the admitted facts in the statement above. The Coroner's Office exhibits
23 bad faith by avoiding the obvious appropriate conclusion that the manner of death
24 was an accident.

25 79. The findings from Drs. Marinovich and Djabourian are also based on
26 the receipt by the Coroner's Office of the Anonymous Letter which the Anesthesia

27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 Consult recites in detail and leads the Coroner's Office to conclude there was
2 gross negligence committed by Valley's medical staff.

3 80. Furthermore, on the basis of the gross negligence conclusion, the
4 Rojeski Final Report calls for referral of Valley's medical staff over to the
5 California Medical Board for further disciplinary proceedings. This conclusion of
6 gross negligence and the call for further disciplinary proceedings are without any
7 evidentiary foundation.

8 81. In the Coroner's Anesthesiology Consult, drafted by Dr. Selma
9 Calmes, she states on page one that she has reviewed "a 1 ½ page anonymous
10 letter to the Coroner by staff who were apparently present during the procedure."
11 Dr. Calmes says the Anonymous Letter "appears to be written by people familiar
12 with the OR and anesthesia routines." However, Dr. Calmes never verified
13 anything about the letter, neither its author, nor its accuracy.

14 82. The Surgical Consult states:

15 "I have discussed the case and autopsy findings with Drs. Djabourian
16 and Marinovich. The pending cause of death is hemorrhage (from
17 laparoscopic surgery) and the likely manner of Death will be Accident. I
18 also reviewed an anonymous letter sent here which outlines various
19 shortcomings of the "1-800-get-thin" surgery centers.... My opinion agree
20 [sic] with reporting this case to the California Medical Board for gross
21 negligence with incompetence. I suggest that the anonymous letter be
22 submitted to the Board."

23 83. The Coroner's illegal site inspection (see ¶¶ 39-45, *supra*)
24 demonstrated that the accusations of the Anonymous Letter were untrue.
25 Nonetheless, defendants have continued to utilize the refuted and contradicted
26 Anonymous Letter as the basis for their findings.

27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 84. The Rojeski Final Report prepared by these five contributing
 2 defendant authors from the Coroner's Office does not indicate any effort to verify
 3 the contents of the Anonymous Letter, nor does it reflect information available
 4 that flatly contradicted the Letter's allegations. At a minimum, the Report should
 5 reflect such contradictory evidence as well as the efforts made to verify the
 6 allegations (and the results of such efforts). Neither the Surgical Consult nor the
 7 Anesthesia Consult demanded or required such verification. If there was such an
 8 effort, the results must be placed in the Report. The absence of verification creates
 9 an extreme departure from the standards of practice in autopsy findings.

10 **Plaintiff Valley Retains Independent Medical Experts to Review the**
 11 **Coroner's Rojeski Final Report**

12 85. In response to the seriously flawed Rojeski Final Report released
 13 confidentially to Valley's legal representatives on January 15, 2013, Valley
 14 responded by providing independent surgical and anesthesiology reviews of the
 15 report as follows from Dr. Michael Sedrak (Exhibit "7"), Dr. Michael Fishbein
 16 (Exhibit "9"), Dr. Ivan Hronek (Exhibit "8"), Dr. Cyril Wecht (Exhibit "10"), Dr.
 17 Terry Simpson (Exhibit "12"), Dr. Juan Felix (Exhibit "13") and Dr. Mirali Zarrabi
 18 (Exhibit "14") (collectively "Valley's Independent Experts").

19 86. Valley's Independent Experts were highly critical of the Coroner's
 20 gross error in claiming the surgery lasted 1 ½ hours beyond 9:45 a.m., when the
 21 anesthesia and the surgery procedure actually stopped. The medical records were
 22 unambiguous that the surgery lasted from 9:15 a.m. until 9:45 a.m., and that the
 23 patient recovered from anesthesia following surgery until she arrested at 10:55
 24 a.m. and was transported to West Hills Medical Center at 11:15 a.m.

25 87. The findings of Valley's seven independent experts, which directly
 26 contradict the five authors of the Coroner's Rojeski Final Report, are significant

27 Case No. _____

COMPLAINT FOR DAMAGES
 AND INJUNCTIVE RELIEF

1 for several reasons. First, with the surgery only lasting 30 minutes instead of two
2 hours, it explains why the attending surgeon and the attending anesthesiologist did
3 not see or notice any unusual bleeding: Ms. Rojeski did not suffer any
4 complications until approximately 10:55 a.m., over an hour after the surgery had
5 ended and she was "closed up."

6 88. Second, as a corollary to the above, Ms. Rojeski was neither awake
7 during the surgical procedure, nor was she "awake and feeling pain as she
8 proceeded along the path to her death over the next 1 ½ hours," as outrageously
9 claimed by the Rojeski Final Report. Valley's independent experts show that by
10 correctly reading the stop time in the medical records, the anesthesia was
11 appropriately stopped at 9:45 a.m. and was not stopped prematurely, recklessly or
12 negligently as claimed by Dr. Calmes and her four colleagues from the Coroner's
13 Office.

14 89. Third, these erroneous factual findings created by Dr. Calmes and
15 blindly repeated by the other four authors of the Rojeski Final Report destroy the
16 scientific and legal validity of the Report. Each one of the Coroner's investigative
17 team repeated the same erroneous factual finding regarding the stop time in
18 making their conclusions as to the cause of death.

19 90. Valley's Independent Experts were highly critical of the Coroner's
20 Report use of the Anonymous Letter in reaching the Report's conclusions. The
21 reviewers pointed out that, after 17 months of investigation (now 19 months),
22 none of the claims from the Anonymous Letter were ever verified. Indeed, the
23 equipment logs at Valley showed the accusations were incorrect, and there was no
24 evidence to support the letter's claims that oxygen tanks were empty, equipment
25 malfunctioned, fluids spilled on the floor, the anesthesiologist wasn't paying
26 attention, or that the time of Rojeski's coronary arrest was inaccurate.

27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 91. Valley presented its first expert report to the Coroner's Office on or
2 about January 24, 2013. Valley's legal representatives personally delivered the
3 expert report prepared by Dr. Michael Sedrak to the Coroner's Assistant Chief
4 Investigator, Ed Winter. Upon being handed Dr. Sedrak's report, Investigator
5 Winter responded that the Coroner's Office was going to issue the Rojeski Final
6 Report without any modification. Investigator Winter further added that Valley's
7 submission of expert reports, along with Rojeski's prior medical records, would, at
8 best, possibly result in the issuance of a supplemental report. Investigator Winter
9 also repeated his warning that the Rojeski Final Report had been shared with
10 Valley and its legal representatives under a confidentiality mandate; any release or
11 disclosure or discussion with a third party, besides a retained expert, would result
12 in the Coroner's Office immediately publicly distributing the Rojeski Final Report.

13 92. Valley provided a total of seven independent expert reports to the
14 Coroner's Office which categorically and unequivocally repudiated the findings of
15 the Rojeski Final Report. Indeed, two of the retained experts, Dr. Fishbein, and Dr.
16 Felix, are Deputy Medical Examiners to the Coroner's Office, just like Dr.
17 Calmes.

18 93. On January 31, 2013, Kenneth Maranga, Esq. informed Valley's
19 counsel, Centurion Law Group, that his office was now the retained counsel for
20 the Coroner's Office. By phone Mr. Maranga also twice repeated the mantra
21 stated by Investigator Winter, that the result of Valley's responses to the Rojeski
22 Final Report would, at best, be discussed in a supplemental report to be
23 subsequently issued by the Coroner's Office and that the Rojeski Final Report was
24 not going to be revised or modified from what had been shown to Valley on
25 January 15, 2013. Mr. Maranga confirmed that position again in a follow up letter
26
27

Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 he sent later that day. *See Exhibit "11" attached hereto and incorporated herein.*⁶
 2 Maranga also stated that any future submissions by Valley regarding the Rojeski
 3 matter had to be submitted through his office.

4 94. Valley's Independent Expert Reviewers have declared that the mode
 5 of death was an "accident," and that the Coroner's conclusions are based upon
 6 errors regarding the end time of surgery and unsubstantiated claims from the
 7 Anonymous Letter.

8 **The Coroner's Imminent Threat to Issue the Flawed Rojeski Final**
 9 **Report**

10 95. Valley's Counsel, Centurion, has asked Mr. Maranga, on four
 11 different occasions between February 18 and March 11, 2013, when the Coroner's
 12 Office would finish its review of Valley's Independent Expert Reports. Mr.
 13 Maranga has only replied that the matter is still under review. Additionally,
 14 Centurion has also asked Mr. Maranga in three separate e-mails whether or not the
 15 matter has been referred to the California Medical Board as repeatedly
 16 recommended in the Rojeski Final Report. Mr. Maranga stated he would check
 17 with his client, the Coroner's Office, but has failed to provide a substantive

18
 19
 20 ⁶ On February 1, 2013, counsel for Plaintiff Valley, Konrad Trope, Esq., of Centurion
 21 Law Group, P.C., sent an e-mail to the Defendant County's retained counsel, Ken
 22 Maranga. In that e-mail, Mr. Trope reconfirmed Mr. Maranga's previously stated position
 23 that the Coroner's Office was not going to modify or revise the Rojeski Final Report. On
 24 February 8, 2013, in response to Mr. Trope's request for access to the slides, photographs
 25 and tissue samples that are referenced in the Rojeski Final Report, Mr. Maranaga stated:
 26 "*As you have been advised, The LA County Coroner is in the process of re-reviewing its
 findings and conclusions. This may, or may not result in modified opinions and
 conclusions. Until such time as that process has been completed, the Coroner's Office
 advises it will not permit access to slides, or photographs.*"

27 Case No. _____

COMPLAINT FOR DAMAGES
 AND INJUNCTIVE RELIEF

1 response. The fact that Coroner's Office refuses to substantially respond to these
 2 reasonable inquiries compels Valley to seek an application for injunctive relief.

3 96. In addition, over the past 19 months, the Joint Commission, the
 4 accreditation agency which oversees medical facilities like Valley, pursuant to
 5 *Cal. Health & Safety Code § 1248.4*, has repeatedly informed Valley that it is
 6 awaiting the issuance of the Coroner's Rojeski Final Report. The Joint
 7 Commission has made its position quite clear that Valley's continued accreditation
 8 hinges on the outcome of the Coroner's Rojeski Final Report.

9 97. The Joint Commission is authorized by the California Medical Board
 10 - Division of Licensing, to oversee the accreditation of ambulatory surgery centers
 11 in California, such as Valley. *See Cal. Health & Safety Code § 1248.4.*

12 98. Because the Coroner's Office leaked the contents of the erroneous
 13 and flawed Rojeski Final Report to Rojeski's heirs in early January 2013,
 14 Rojeski's heirs, instead of settling their wrongful death lawsuit filed in September
 15 2012, have announced that they will be amending their complaint to seek punitive
 16 damages and will be continuing their lawsuit, thus unnecessarily subjecting Valley
 17 to additional damages and legal fees attributable to the Constitutional violations
 more fully described herein below.

18 **Declaratory and Injunctive Relief, Irreparable Harm, Damages Suffered**
 19 **By Plaintiff and Color of Law**

20 99. As a result of the conduct described above, Plaintiffs have been and
 21 continue to be injured, including suffering loss of income, lost profits, damage to
 22 its professional reputation, damage to its goodwill, damage to its business
 23 operations, damage to its ability to effectively recruit physicians and staff as a
 24 medical facility, expenses in retaining consultants and attorneys to attempt
 25 (unsuccessfully) to convince the Coroner's Office and its representatives that its

26
 27 Case No. _____

COMPLAINT FOR DAMAGES
 AND INJUNCTIVE RELIEF

1 statements and conclusions are false and without any evidentiary foundation,
2 diversion of resources (including staff and professional time) from carrying out its
3 normal medical activity to address the problems occasioned by Defendants'
4 conduct, injury to its constitutional rights, the exacerbation of claims in the
5 Rojeski lawsuit that it was responsible for her death, and the need to prepare to
6 defend itself before the relevant licensing/accreditation authorities in California, to
7 name some of the injuries caused to date.

8 100. Plaintiff is entitled to declaratory relief with respect to the
9 unconstitutionality of the conduct of the Coroner's Office and its agents and with
10 regard to the falsity of the evidence that forms the basis for the Coroner's Report,
11 and an injunction preventing the continuing participation of the Coroner's Office
12 and its agents in the investigation into the Rojeski death, including participation in
13 releasing any reports related thereto. The pattern of unconstitutional and unlawful
14 conduct in which the Defendants have engaged demonstrate that they are so biased
15 and irrationally and arbitrarily hostile to Plaintiff as to disqualify them from any
such further role.

16 101. Without such a declaration and injunction, Plaintiffs will be
17 irreparably harmed. It will face the ongoing threat that its business will be
18 completely destroyed before it can successfully defend itself. Official issuance of
19 the current report, based on fabricated evidence and information whose falsity at
20 this point is beyond dispute, would almost certainly lead to withdrawal of Valley's
21 licensure/accreditation in the short term and possibly longer, with the likely effect
22 of destroying what is left of its business. If this false Coroner's Report is released,
23 as threatened by the Coroner's Office, it will almost assuredly lead to the financial
24 collapse of Valley, a collapse from which it is unlikely that it could ever recover
25 even if ultimately vindicated.

26
27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 102. All of the Defendants, while often described in the past tense
2 throughout the complaint, continue to engage in the conduct set forth herein to the
3 present, and, unless enjoined by this court, will continue to do so. The conduct of
4 defendants as alleged herein has been, continues to be and, unless enjoined by this
5 court, will continue to be deleterious to the Plaintiff and its fundamental rights.
6 Unless they are restrained from doing so, Defendants will continue to engage in
7 such unlawful conduct.

8 103. Unless this Court acts to enjoin the unlawful conduct described
9 herein, Plaintiff will continue to suffer irreparable harm. Plaintiff has no adequate
10 remedy at law. Damages alone are insufficient in light of the continuing violation
11 of its constitutional rights and the threat to its very existence as a viable entity.

12 104. Plaintiff seeks injunctive relief under both federal and state law.

13 105. In engaging in the conduct described above, all of the Defendants,
14 when sued in their individual capacity, acted willfully, wantonly, maliciously,
15 oppressively, and/or with conscious or reckless disregard or deliberate
16 indifference to the Constitutional rights of Plaintiff Valley. Therefore, Plaintiff
17 Valley is entitled to seek punitive damages against said Defendants.

18 106. At all times herein, the individual Defendants acted or purported to
19 act within the course or scope of their employment or agency and were acting
20 under color of law as employees or agents of the County Coroner's Office, or
21 persons acting in concert with, and under the direction and control of, the County
Coroner's Office.

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27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 **FIRST CLAIM FOR RELIEF – VIOLATION OF CONSTITUTIONAL**
2 **RIGHTS UNDER 42 U.S.C. § 1983**

3 *(Damages Against All Defendants Sued In Their Individual
4 Capacity)*

5 107. Plaintiff alleges and incorporates, as though fully stated herein, all the
6 foregoing and any subsequent allegations and paragraphs set forth in this
7 Complaint.

8 108. Defendants, and each of them, personally and/or as part of a
9 conspiracy, acted, under color of state law, to violate Plaintiff's constitutional
10 rights, including but not limited to:

- 11 a. Violate its due process right to a governmental investigation not
12 based on false and/or fabricated evidence;
- 13 b. Violate its due process right to an unbiased governmental
14 investigation not based on false and/or fabricated evidence;
- 15 c. Violate its due process right to not have exculpatory evidence
16 destroyed in bad faith;
- 17 d. Violate its First Amendment and due process rights to petition the
18 government and to have access to the courts;
- 19 e. Violate its First Amendment rights to engage in lawful speech
20 without being retaliated against for doing so;
- 21 f. Violate its First Amendment rights to engage in lawful speech
22 without having its right to do so infringed upon and chilled by the
23 actions of governmental agents or employees;
- 24 g. Violate its due process rights to petition the government and to
25 have access to the courts;

26 Case No. _____

27 COMPLAINT FOR DAMAGES
 AND INJUNCTIVE RELIEF

- 1 h. Violate its Fourth Amendment right not to be subjected to an
- 2 unlawful search and seizure;
- 3 i. Violate its equal protection and/or due process right not to be
- 4 singled out for irrational and/or arbitrary discriminatory
- 5 treatment.⁷

6 109. Defendants' actions violated Plaintiff's rights under the First, Fourth,
7 Fifth and Fourteenth Amendments to the United States Constitution. To the extent
8 that any Court were to determine that the foregoing claims are appropriately
9 brought under a different or additional constitutional right not expressly named
10 above, such claims are also brought under such alternative or additional
provisions.

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21 ⁷ To avoid any possible confusion, Plaintiff Valley is claiming to be a class of one for
22 equal protection purposes because Valley and its medical staff was repeatedly subjected
23 to intentional treatment that was clearly different from others similarly situated, and there
24 is no rational basis for the difference in treatment. In other words, Valley was subjected
25 to an ongoing investigation by the Coroner's Office without any legitimate basis for doing
26 so, and the Coroner's Office has subsequently, in the Rojeski Final Autopsy Report,
recommended that Valley and its medical staff be referred for further prosecutorial
actions on the basis of deliberately fabricated false evidence.

27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 **SECOND CLAIM FOR RELIEF – VIOLATION OF CONSTITUTIONAL**
 2 **RIGHTS UNDER 42 U.S.C. § 1983**

3 *(Monell Damages Against The County of Los Angeles, the County*
 4 *Coroner's Office, And Defendant Lakshmanan Sathyavagiswaran*
 5 *In His Official Capacity, and Against Defendant Sathyavagiswaran*
 6 *In His Individual Capacity for Supervisory Liability)*

7 110. Plaintiff alleges and incorporates, as though fully stated herein, all the
 8 foregoing and any subsequent allegations and paragraphs set forth in this
 9 Complaint.

10 111. Defendant County of Los Angeles, County Coroner's Office and
 11 Defendant Lakshmanan Sathyavagiswaran (hereafter the "Monell Defendants") are
 12 sued under *Monell v. Department of Social Services of the City of New York*, 436
 13 U.S. 658, 98 S.Ct. 2018, 56 L.Ed.2d 611 (1978).

14 112. On information and belief, Defendant Sathyavagiswaran was, at all
 15 times herein relevant, an employee of the Coroner's Office and had the final policy
 16 making authority for the conduct of the Coroner's Office and its investigation,
 17 including having authority over the other individual Defendants named herein.
 18 Defendant Sathyavagiswaran, as the policy maker for the County Coroner's
 19 Office, maintained, enforced, tolerated, ratified, permitted, approved, acquiesced
 20 in, and/or engaged in the conduct and constitutional violations alleged above,
 21 thereby making the County directly liable for these actions.

22 113. Alternatively, the ongoing conduct over 19 months of repeated
 23 constitutional violations of Plaintiff's constitutional rights – separated in time and
 24 of varying types – constitute a custom and practice sufficient to make the County
 25 directly liable under *Monell* for the conduct alleged herein.

26 Case No. _____

27 COMPLAINT FOR DAMAGES
 AND INJUNCTIVE RELIEF

1 114. Additionally, Defendant Sathyavagiswaran is individually liable
2 under the doctrine of supervisory liability because (1) he was personally involved
3 in the constitutional violations alleged herein (including but not limited to the use
4 of fabricated and false evidence), or (2) he was aware of and acquiesced in the
5 constitutional violations and acted or failed to act with a reckless or callous
6 disregard for Valley's rights. Despite knowledge of the violations alleged herein,
7 he took no action of any kind to prevent or correct them. In short, Defendant
8 Sathyavagiswaran was unconstitutionally silent in preventing or correcting these
9 violations.

10 **THIRD CLAIM FOR RELIEF – VIOLATION OF STATE LAW**

11 *(Against All Defendants For Injunctive Relief With Amendments*

12 *To Be Added For Damages Claims Once Plaintiff Is Able to File*

13 *The Necessary Administrative Claims Without Fear Of Retaliation)*

14 115. Plaintiff alleges and incorporates, as though fully stated herein, all the
15 foregoing and any subsequent allegations and paragraphs set forth in this
16 Complaint.

17 116. Defendants violated many state laws governing the conduct of the
18 Coroner's Office, some of which provide a partial basis for injunctive relief,
19 provide protected liberty and/or property interests, and provide potential claims for
20 damages.

21 117. Once conferred, California law provides a physician at least a
22 protected property interest in his/her license to practice medicine and provides an
23 accredited medical facility at least a protected property interest in his/her/its
24 accreditation.

25
26
27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

1 118. Other relevant state laws include, but are not limited to, (1) Cal.
2 Gov't Code § 27491.4 (coroner must act in accordance with medico-legal
3 practice); (2) Cal. Gov't Code § 27491.5 (coroner's report must be in accordance
4 with facts ascertained from inquiry, autopsy and other scientific findings); (3) Cal.
5 Gov't Code § 27491.45 and Cal. Health & Safety Code § 7151.2 (regarding
6 appropriate organ harvesting); (4) Civil Code § 815.6 (violation of mandatory
7 duty), and (5) Cal. Civil Code § 52.1 (use of threats, intimidation or coercion to
8 interfere and attempt to interfere with exercise of rights secured by Federal or
9 State Constitution or law), as well as violation of the California Constitutional
10 protections for freedom of speech and petition, freedom from unlawful searches
and seizures, and the right to due process and equal protection of the law.

11 119. Due to the intimidating and harassing conduct of Defendants as
12 previously alleged, Plaintiff has not filed an administrative claim under Govt.
13 Code § 910 for damages, and accordingly does not currently allege state law
14 damages claims. However, Plaintiff, with the anticipated protection of the court as
15 requested in this complaint, intends to proceed to file such claims and to move to
16 amend the complaint to add state law damages claims at the appropriate time.

FOURTH CLAIM FOR RELIEF – INJUNCTIVE RELIEF AND DECLARATORY RELIEF

(Against All Defendants For Injunctive and Declaratory Relief)

21 120. Plaintiff alleges and incorporates, as though fully stated herein, all the
22 foregoing and any subsequent allegations and paragraphs set forth in this
23 Complaint.

24 121. Based on the ongoing violations of law and of Plaintiff's
25 constitutional rights, and the irreparable harm Plaintiff will experience if this

27 Case No. _____

**COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF**

Court does not act, and the fact that there is no adequate remedy at law, Plaintiff Valley seeks an injunction against the Coroner and its staff to prohibit it from:

- a. any further role in the investigation into the death of Paula Rojeski.⁸
and
- b. releasing the Coroner's Final Rojeski Report.

122. In the event the Court does not grant an injunction, then Plaintiff seeks declaratory relief stating that 1) it violates Plaintiff 's constitutional rights, including its right to due process of law, for the Coroner's Office to assert in any official report or proceeding that Paula Rojeski's surgery lasted more than 30 minutes, or that she was in surgery or under anesthesia at the time of her cardiac arrest at 10:55 a.m., because that is a statement unsupported by any evidence and is directly contrary to all available medical records; 2) it violates Plaintiff's constitutional rights, including its right to due process of law, for the Coroner's Office to quote from or rely on the unverified and unsupported Anonymous Letter, which could only be validly used, to the extent it could be used at all, as an investigation tool, the contents of which have to be, but have not been, independently verified; and 3) it violates Plaintiff's constitutional rights, including its right to due process of law, for the Coroner's Office to forward to any governmental body referrals for criminal, civil, or administrative proceedings that rely in any respect on the unsupported statements described in ¶ 124(1) and (2).

PRAYER FOR RELIEF

Plaintiff seeks judgment as follows:

⁸ This would leave the County free, if it so decided, to choose an independent or out of County Coroner's Office, which, after appropriate investigation, would be free to issue its own Report.

Case No.

COMPLAINT FOR DAMAGES AND INJUNCTIVE RELIEF

- 1 A. Preliminary and permanent injunctive relief prohibiting the Los Angeles
- 2 County Coroner's Office from any further role in the investigation into the
- 3 death of Paula Rojeski, including releasing its report regarding that death.
- 4 B. In the event that injunctive relief is not granted, declaratory relief as
- 5 described in ¶ 124, *supra*.
- 6 C. Compensatory, general, and special damages against all Defendants, and
- 7 each of them, in an amount according to proof;
- 8 D. Punitive and exemplary damages against all Defendants sued in their
- 9 individual capacities, and each of them, in an amount according to proof;
- 10 E. Pre-judgment interest according to proof;
- 11 F. Reasonable attorney's fees and expenses of litigation as allowed
- 12 by 42 U.S.C. § 1988, California CCP § 1921.5, California Civil Code §
- 13 52.1(h) and other applicable law;
- 14 G. Costs of suit reasonably incurred;
- 15 H. That Defendant Coroner's Office be required to pay any judgment
- 16 pursuant to law.

17 DATE: 03/28/2013

18 Respectfully Submitted,

19 KAYE, MCLANE, BEDNARSKI &
LITT, LLP

20 By: /s/ Barrett S. Litt
Barrett S. Litt

21 CENTURION LAW GROUP, P.C.

22 By: /s/ Konrad L.Trope
Konrad L.Trope

23
24 Attorneys for Plaintiff
25 VALLEY SURGICAL CENTER, LLC

26
27 Case No. _____

COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF

DEMAND FOR JURY TRIAL

Plaintiff Valley Surgical Center, LLC demands a jury trial, as provided by R.38(a) Federal Rules of Civil Procedure.

DATE: 3/28/2013

Respectfully Submitted

KAYE, MCLANE, BEDNARSKI &
LITT, LLP

By: /s/ Barrett S. Litt

Barrett S. Litt

Attorneys for Plaintiff

VALLEY SURGICAL CENTER, LLC

CENTURION LAW GROUP, P.C.

By: /s/ Konrad L.Trope

Konrad L. Trope

Attorneys for Plaintiff

VALLEY SURGICAL CENTER, LLC

**COMPLAINT FOR DAMAGES
AND INJUNCTIVE RELIEF**